already there. And so is off the list. But osteopathic manipulation, cranial especially and others, is used for these areas. And so should be on the list.

And then I'd like to look at it further.

DR. MURPHY: Thanks.

CHAIR LEINENKUGEL: Thanks Wayne. And I have Sheila taking some notes. And she added those as well. Thank you.

DR. MURPHY: And we'll be going back to Sheila with questions about, you know, how far we can go. Because it affects, you know, how many people we need to put on this.

DR. JONAS: That's fine.

DR. MAGUEN: And just to add to the models, you know, one thing that we should do too, is there are eight modalities that whole health recommends too.

So we should look at the list, this list and compare it to that list to make sure we're hitting all of those issues as well.

DR. MURPHY: I'll ask Allison to help us with that.

MR. ROSE: Mr. Chairman, I also would recommend what my fellow Commissioners and lady have recommended here. We're at the start.

We need to take a little bit of time until we shoot out of the gate. I don't know.

And I don't know how it's going to impact. I hope it won't impact, I mean, we have a deadline.

That's it. We got to make that deadline. Thank you.

COLONEL AMIDON: Mr. Chair as well. I just want to make sure in the search for the perfect we don't forego the effort that could start right now.

So given that there's a list right here, I suggest we move forward sufficiently to do so.

Secondly, I just wanted to make sure I understand the assumptions and the terms.

You're going to look for formal study output in support of this?

DR. MURPHY: We should go over this.

COLONEL AMIDON: Okay. Well, then my question being then is, I know within each one of these, as an example, of organizations out there doing the work that are attempting to capture data, but haven't formalized data output yet.

And in doing so, I think I know of two cannabis studies ongoing right now. And I would like to recognize one of the public members in attendance today if I could, Mr. Chair.

CHAIR LEINENKUGEL: Please.

COLONEL AMIDON: Dr. Heather Kelly from the APA. Thank you so much for being here.

And I just wanted to say, Dr. Kelly since 1998 has served as a senior lobbyist in APA's Science Government Relations Office.

And in addition, her new portfolio

includes advocating for the mental health and well-being of military personnel, Veterans and their families. And communities that have been supporting this, psychologists that serve those who served.

So, it's very nice to have a professional organization in attendance today. Thank you so much.

DR. MURPHY: So, to answer your question, we're going to be looking to gather the published literature for you.

We -- you know, you can certainly look at non-published work from either the NICoE or other organizations.

But really to determine whether these treatments are effective, you've got to go through a formal process. And part of that process, after we've developed the scope, is developing the key questions.

And those key questions will guide the review process and give all of us an understanding of what your objectives and

priorities are.

So I'd like to walk you through that next step. And we've done the --

CHAIR LEINENKUGEL: Fran, could I interject for just a minute and give you a ten minute break while I bring in the Acting Secretary?

We have him scheduled for 10:30.

DR. MURPHY: I assumed that I'm stopping here. He takes over, and I'll finish when he stops.

CHAIR LEINENKUGEL: Perfectly. Let me get Mr. Peter O'Rourke.

(Whereupon, the above-entitled matter went off the record at 10:31 a.m. and resumed at 10:35 a.m.)

CHAIR LEINENKUGEL: All right, we are back in session after that five minute break.

This is a public session, so we are on the record. There are public observers.

And, I have the opportunity at this

point to introduce a friend of mine that we've gotten to know over the last 19 months.

Peter O'Rourke brings a highly diverse skill set in transformation, innovation and leadership honed by over 27 years of demanding fields and challenges.

He served in the military as a Navy enlisted plane captain, an Air Force officer and logistician.

He is a Lean Six Sigma Master Black Belt and has held positions in consulting in government service including service as Senior Policy Advisor, Congressional Staffer and Executive Director for nonprofits focused on generating support for federal government efficiency.

Peter has served as the VA Chief of Staff from February 16, 2018 to May 29, 2018. And, in that short period, I can tell you he helped oversee the Department through the appointment of Acting Secretary Robert Wilkie, now to be Secretary Robert Wilkie.

And, was instrumental in finalizing VA's electronic health record modernization contract as well as working with the White House, Congress and Veterans service organizations to secure the passage of the landmark VA Mission Act.

Prior to becoming VA Chief of Staff, O'Rourke served as the first Executive Director for the VA's Office of Accountability and Whistleblower Protection.

And, in that position, he established and led this new office to which is the first of its kind in federal government.

In this role, he quickly became a trusted advisor to many leaders throughout the Department on accountability and culture issues.

Mr. O'Rourke is a 1998 graduate from the University of Tennessee and United States Air Force Institute of Technology in 2005.

At this time, it's my pleasure to introduce my friend and Acting Secretary, Mr.

Peter O'Rourke to the Commission.

(APPLAUSE)

CHAIR LEINENKUGEL: You do know that you have to turn this on.

MR. O'ROURKE: Is it red now? Okay, good. Red usually means stop, which for me, talking I should stop.

No, thanks, Jake, I appreciate that. I bring greetings from the incoming Secretary, Mr. Wilkie who, all indications are, he'll be sworn in on Monday, so that's -- we're all excited about that and especially me.

Being an Acting Secretary is a great honor from the President to fill that gap, I guess you could call between the times. But, I can fully appreciate what it means to run an organization with the scale, the geographic scope and everything else that goes along with the serving Veterans.

So, it's, like I said, been an honor, but I am very much looking forward to supporting our new Secretary as he transitions

in and continues on the good work that we've started here that I know that you all will -- are beginning today and will continue to do.

It's an area that we all are familiar with and I think has probably touched us in a lot of different ways.

Prior to this -- prior to these jobs, I'm sure throughout our life, I'll tell you one quick story that is pretty recent for me and, for me, is probably going to be a very informative one.

I got a chance to speak with folks at DAV at their convention a couple weeks ago and prepared the speech and, you know, go through all that and you're hitting the points about the different DAV's a lot focused on, you know, claims processing and things like that.

So it was good to highlight some of the good work that folks at the Veterans' Benefits Administration is doing and highlight that with that with this group and talk through some of those issues.

But, one of the things that I talked about in the speech and I'll the story, I wasn't really prepared, I mean, I knew the issues, I had looked into the suicide statistics and all those things. In fact, I had gotten the full brief on the new CDC stats a couple weeks ago and they're heartbreaking, wrenching.

I mean, it's what we would expect being human. But, what I also didn't realize when I became the Acting Secretary was the alert message on suicides that happen on VA campuses. They come direct pretty much the day of. I'll see those and read the initial details and then get the follow up and stuff like that.

And, the Thursday prior to -- the speech was Saturday morning, Thursday prior I had gotten the one notice about a 77-year-old Veteran who had attempted suicide and I don't really even want to have to go and do the follow up to find out if he was ultimately

successful.

But, he had made a good effort, I guess is the way to put that.

And then, Friday, got the second one of an 86-year-old Veteran who was successful in suicide.

I remember getting the first one of those roughly a few days into this job and I remember being very engaged in the sense of wanting to know the story, what was going through this person's head.

You know, they had just walked out of the VA, walked to the parking lot, took their life. What was going on? What was their diagnosis? Looking for insight, looking for a reason, which I think is probably everybody's reaction when they get into this. Why? You know, answer that question for me.

And, so, got those two emails Thursday and Friday and it kind of just weighed on me. And, you know, the speech was good, I had practiced it a few times.

But, I woke up Saturday just thinking, you know, you've got to say something about this.

So, I ad libbed a little bit at the end of the speech and really used a friend of mine who's a 86 -- or an 80-year-old Veteran who I've known for quite a long time and talked about Ed.

You know, Ed and I talk roughly at least once a week, share a few emails. So, we're in constant contact.

He's gone through a couple bouts of prostate cancer, some of other stuff. But, he's still kicking. He's an old Marine so he's not going to get taken out that easy.

But, it's always getting with him. And, he's gone through a couple periods where, you know, it's just weighed on him a lot. And, you know, we've had some good conversations, just kind of being a friend kind of thing.

And, he's got plenty of folks to talk to, too. But, it was that engagement.

So, I encouraged the folks there not to follow my example but, just, you know, they all know people like that and that are struggling or could be struggling, just reaching out to them and kind of just ended it there. It was kind of clumsy, but it was just ad libbed, but it was what was on my heart at the time.

And, Garry Augustine, who's the National Director for them, comes to me at lunch, we had lunch with Chairman Roe and so, he wanted to pass on to me that, evidently, there was a Veteran in the crowd, a mother who was notified that her 32-year-old son had committed suicide.

And so, of course, he tells me this story and he said how they, you know, had some mental folks there from the local VMC and took care of her and they were, you know, just concerned about her. But, you know, basically, he was highlighting how she was getting taken care of.

Of course, I felt like absolute crap. You know, I figured, well, tore open a wound that was probably pretty fresh for this lady. You know, I just felt like crap.

And, I said, really? I mean, and I told him that, I said, man I feel bad now for even bringing that up.

He goes, no, no, she got the call after your speech. Literally about an hour after the speech wrapped up about -- probably about 9:45, 10:00, sometime between 10:00 and 12:00, she got a call that her son had committed suicide.

Both were deployed -- had been -- had deployed to Iraq and Afghanistan, both were Veterans.

So, it still felt just as bad, but it was -- it really kind of highlighted that stuff happens and for reasons that we're still struggling to understand.

So, that leads into the work that you all are doing both on the therapy side but

also to help us, you know, promote from our perspective, I guess, from the VA on how we can do more, what we can do effectively, how we can get the word out.

I don't know how to tell these stories other than just to tell them and encourage folks to do everything they can.

I know there are scientific things we can do. We can be smart about things, we can look at data.

I guess from the layperson's standpoint, from my perspective, it's just, you know, how do you engage with people on the frequency that you do it and those things.

I don't think those are solutions. I think that's just a reaction to it and kind people on emotionally driven human nature stuff.

So, anyway, so that was -- that part of it getting into the important work that you all will be doing, I can communicate a few things.

One, you have a 100 percent support from leadership of the VA. Unquestioning, unqualified. I mean, it is whatever you all need to do this work, you're going to get.

We all take this -- I know Mr. -- I'll speak for Mr. Wilkie and the rest of the leadership team. I mean, this is always top of mind for us and probably the most frustrating thing that's top of mind because this is something that we don't -- that we struggle with, especially after learning that, you know, really suicide rates haven't changed.

Mental health struggles across the Department while we invest in it, we work, we try to hire, we do all these things, still, you know, it's a battle that keeps going.

So, you have that support.

As we, you know, change, which is inevitable in any organization this size, we want to make sure that we're cognizant of what you learn and what your recommendations are.

So, I can also tell you that, I

guess, Boomer can attest to this, one of the things that we changed at least when I got here and I'll make the strong recommendation to Mr. Wilkie is that we, as a leadership team, as a Secretary, Deputy Secretary, Chief of Staff, you know, those are a leadership review your findings and, frankly, review them uncoordinated, or whatever you want to call it, unconcurred on.

I'd like to know exactly what you guys are saying. I don't need an administration to Vet it for me. So, I'll encourage Mr. Wilkie to do the same thing. I think he'll be right on board with that.

So, I want you all to have the assurance that your recommendations, your comments, your feedback, whatever form that takes comes to us directly.

We'll still have the concurrence process and all that good stuff, that's appropriate and proper. But, at the end of the day, these are hard decisions that have very

real consequences. So, you all deserve to have those hears unfiltered.

So, and participation with these meetings. I mean, I know Jake and I know how aggressive he is, so I will not set myself up to coming to every single one of them, but I promise to be to as many of them as I possibly can. And, I know Mr. Wilkie will feel the same way as well as the rest of the team.

So, you will get the support from us that you need. And, if you ever don't just let us know.

With that, I would love to hear any questions you all have, anything you want me to pass on to the new Secretary? Any comments? Any feelings? I'm open to listen.

CHAIR LEINENKUGEL: Mr. Acting Secretary, if I may, let me start with my Co-Chair, Mr. Tom Beeman. I already introduced him, but, Tom, very briefly, in 30 seconds or less, an overview for Peter, if you will, on your background and why you're part of the

Commission?

Then we'll go around the table. There's actually, Mr. Acting Secretary, there are eight out of the ten designated spots filled at this time. We have a quorum.

I can tell you from yesterday's meeting, this is a very active, proactive group. It will be stimulating and I was so happy to hear of the approach that you have and that Secretary -- Incoming Secretary Wilkie will have.

And, my intent, even though I'm not mandated, only by letter after 60 days of meeting, was to give you a brief overview of whether or not we're receiving the proper support, not only from the VA, but any other agencies or governments departments that need to provide us materials in a quick, responsive way.

I told Dr. Stone yesterday that, because of his VHA duties, that I would be giving him a monthly, if not weekly, briefly on

if there are any roadblocks or barriers and if he could deal with those and he immediately said, absolutely. And, I plan to do the same with you and the Secretary.

DR. BEEMAN: Tom Beeman, glad to have you here, sir.

I'm a 27-year Veteran of health care. I've been a CEO of Health System for the last 27 years or so. I'm with Penn Medicine.

I was also the Assistant Deputy Surgeon General for the Navy. So, I'm a retired two star.

And, I was the first Commander of the National Intrepid Center of Excellence which really has helped inform my work.

DR. MAGUEN: Hi, so glad to have you here. I'm Shira Maguen. I'm working at the San Francisco VA.

I am a clinician, a researcher and also do training for our trainees, both psychiatry and psychology.

I'm a clinical psychologist by

training and have been in the VA since 2001. So, really glad to be part of this. And, an open invitation to come visit us.

(OFF MICROPHONE COMMENTS)

MR. ROSE: Good morning, sir. My name's Jack Rose and I'm a 26-year Veteran with the Navy. And, I've been involved -- also from Wisconsin.

And, a mental health advocate. And, I've been involved with the National Alliance on Mental Illness here since probably 18 years.

And, I look forward to supporting this Commission. And, thank you very much for the opportunity.

DR. KHAN: Jamil Khan, United States Marine.

(OFF MICROPHONE COMMENTS)

COLONEL AMIDON: Good morning, sir, Matt Amidon, U.S. Marine as well.

(OFF MICROPHONE COMMENTS)

COLONEL AMIDON: I wasn't down in Dallas, no, sir. I was actually out on

military duty and this is why this is near and dear to my heart.

On the last drill weekend less than a week ago, we had a memorial service for a young Marine who decided to take his own life in the barracks in Fort Worth.

And so, it's deeply meaningful to me. But, you have a chance to hear about what we do at the Military Service Initiative.

And, I think we uniquely exist to the benefit of this Commission at the intersection of public and private and provider and consumer. And so, can be an important broker in this effort. And, I'm deeply honored to be here.

Thank you.

DR. JONAS: I'm starting to feel lonely here, I'm Wayne Jonas, United States Army.

(LAUGHTER)

DR. JONAS: So, and I think the only physician on the panel actually. I'm a primary

care doc. I still see patients at Fort Belvoir which is a purple suited training program actually up there.

And, one of the biggest primary care training programs in the DoD anyway.

And, also have a long history of research at Walter Reed, NIH, Uniformed Services University.

I now run a foundation that supports Veteran area, DoD areas in the area of whole person and integrative health. And, I practice that in the military hospital near here.

And, so, really would like to see -- just so supportive of what Jake's doing and the Commission is doing to try to accelerate care, not only for our Veterans, for our nation which deeply needs this.

CHAIR LEINENKUGEL: So, I think you can see, Mr. Acting Secretary, that this is just a solid group and we're going to add to this group over the next 30 days as well.

There is a person I want to

introduce you to that's in the bullpen right now warning up and not officially vetted. So, when we're walking out the door, I'll bring out this person to introduce him to you.

That being said, thank you so much for everything that you have done for your 19 months of being within the VA.

And, I want to tell the group this. Peter O'Rourke was the quiet one when I first came in in January of 2017. And, found out to be the smartest one and the hardest worker.

As he told me, I may not be the smartest person that you brought in, Jake, but I'll be the hardest worker. And, he was that.

And, I gave Peter two assignments, and he completed both of them. And, one assignment was to get the Veteran ID card off the ground that was languishing, again, for two and a half years with nobody taking ownership and The Hill demanding for the VA to finally take action.

Peter took action and did it within

six months. I have my card. I know Veterans that are receiving their cards. They think it's the best thing since VA health care.

Even though it gives them a 10 percent discount at various stores, but thank you for that.

And also, setting up and watching him set up the Office of Accountability and Whistleblower Protection is a well-kept secret within the 15 mile radius of Washington, D.C.

And, the people that he brought in and how he has done a great job at bringing in some of the best and brightest to set this office up. He is fantastic.

And, you've got to remember, it's just starting. And, I think it's going to be a best practice in years to come and Peter O'Rourke is the one with the thumb print on that.

So, Peter, thanks for your service and thanks for being a fantastic Acting Secretary to calm the waters over this period

and get the VA on the right mission track again.

And, this Commission, as the COVER Commission, is very much a part of where we're going to be going in the future with health care.

Thank you, sir.

MR. O'ROURKE: I don't know if I calmed the waters as Acting Secretary, but I definitely stirred up the waters a little bit.

(LAUGHTER)

MR. O'ROURKE: But, that needed to be done. So, no, I appreciate that, thanks.

Any questions from anybody? I know it's still probably new, but anything you want me to take back? I'm more than happy to do that.

DR. JONAS: I'm sorry, I didn't mean to -- I don't mean to jump in here too quickly, but I did have a very specific question, but I need to tell you why I am asking this.

So, I was down at the St. Louis VA

about two months ago looking at their whole health program doing a deep dive in there.

And, there was a Veteran panel they had set up, using varies panels to look at. One of the Veterans, long hair, tattooed, former Marine guy, okay, had -- was coming in for his back pain. And, he had chronic back pain, had multiple interventions and treatments, still had chronic back pain.

He met with a peer to peer counselor, okay, and did a personalized health plan which is what they are doing down there, we're interested in.

He got a personalized health plan and the peer said, why don't you come over to the yoga class with me? He said, yoga? Are you kidding me? No, just come on over, we'll try it out.

He started the yoga class, his pain improved and then he said something that just startled everybody in the room. He said, yoga saved my life.

And, I said, what do you mean? And, he said, I thought about suicide every single day before this class and I would never tell anybody about it because I know what happens when you tell them that. Okay?

And, we were just stunned. Okay? We're going to get an evidence review that is likely going to say, yoga does -- there's insufficient evidence to use yoga for PTSD. Okay?

So, my question to you is, how are we going to -- how is the VA and the nation going to determine value on investment? And, I use that term specifically over return on investment because we're looking at value which has to hit at something.

And, Drew yesterday put me in touch with a great study done in 2007 where they looked at designs of health care around that.

And, as someone who's going to be looking at accountability, how are we going to actually measure the accountability issue when

it comes to value on investment for something like that?

MR. O'ROURKE: So, there's yoga, there's hyperbaric, there's -- and these are things that I'm new to. I'm not a clinician, obviously, but I've heard those and you see the stories.

And, I've talked to Congressmen that -- and women that have their opinions about things with -- that are light on the scientific data side.

I think this Commission is going to go very far with providing us the qualified reasons why we should do these, maybe not the quantified.

And, I relate that back a little bit to what we're doing in benefits, actually. Because we do the buddy statements and things like that. I mean, when there was no record, when there's those, we've expanded to provide different methods of justification or different methods of validation of those verification of

them.

I don't know what the answer is, but I know that getting a group like this together to start advocating for it in an organized way, not an average see from the outside in saying, you know, hey, this is great, it's the only thing that worked, you know, take Vitamin E all day, you'll be fine sort of thing.

More recognizing what the effect of long term war is, because we can't quantify that either, by the way. Right? I mean, I haven't seen a study. We see anecdotal type things, things like well, what really happens.

I mean, if we want to go back in history and look at the Spartans or we want to go back and, you know, Greek and Roman history, I'm sure we could, you know, come up with stories about the long term effect or go back to World War I, which ever.

At the end of the day, it's more of the organizations, plural, so it's us and DoD and by association, the rest of the federal

government saying, let's just be honest about this with ourselves.

What is our mission really going to be? What are we truly going to do for Veterans and what are we not? Are we going to encourage them to go do things or are we going to mandate it, i.e., fund it for them?

So, I think those are the harder questions that we really have to look at. And, I mean, we have this debate right now with the presumptions and, you know, types of health care, things that we're going to take care of.

So, I think those are open questions for good conversation for debate for as much evidence as we can find and then we just really taking our Veterans for who they are, what they are and then just dealing with that and making this really focused.

Because, for the one Marine that yoga, you know, he admitted it, we'd probably have ten people that wouldn't admit to that. And, then, a few others say, no, I didn't even

think about that at all.

And, half of those like the yoga and half of them say, no, I'd never do that.

I mean, there's going to be a lot of variance in that. And, at the end of the day, if it's a personal lifestyle choice kind of thing that's going to help them, I think we should encourage all good type things.

I mean, if we can define that it's good, of course, we encourage it. Of course, that's a cop out answer, right, because it's not, okay, yes, but are you going to fund it? Are you going to make it a benefit?

And, that's -- then we start crossing lines into other broader conversations of exactly what benefits are we going to provide and is it, you know, earned in that? We'll leave that for later on.

I think what work that you guys are doing are going to help us with the validation of, yes, these are things we should do.

I mean, I sat with the folks from

Columbia that are developing the equine therapy handbook, you know, the actual observable, you know, responses to that and how should we do it.

And, I'm pretty sure they probably just kind of skipped over that. Can we actually say, playing with horses is going to, you know, do X, Y and Z? Or just result in X?

And then, kind of just jump to, it's like, hey, it's observable. It's kind of like what we are -- we have puppies now in the lobby every month. I hope it's every month, because that's what we all kind of decided to.

Not because we have a scientific study that says playing with puppies is great, but anybody can walk in the lobby on the day that the puppies are in the lobby and realize, oh my gosh, the morale of all of our employees at VA just went through the roof.

Now, that may have only lasted for about ten minutes. As soon as they got in the elevator and got stuck there for a few minutes.

But, for that brief moment, those puppies made their day.

I think it was the same thing we observed with horses and everything else.

I mean, there's things that we just know. Do we need to study them to death and 25 years later realize that, yes, this is something we should have been doing for the last 50?

I mean, that's for us to provide reasoned arguments and as much qualified or quantified data that we can and then let politicians decide what they're going to fund or not, what we can encourage.

Because, I can encourage a Veteran, hey, go play with some puppies, go ride a horse. And then, maybe find a charity that'll help them do that or find other methods for them to get that done.

If we know these are good things to do, then that's things we can probably get out through our systems and we can start doing

this.

We're a pretty scaled up organization. So, if we just say, hey, this would be a great thing for a Veteran service organization to help us do, I mean, that's where kind of the experience for the Veteran ID card came in is, yes, we had a funding problem with that and that's what was the major roadblock.

Because we connected over our own internal roadblocks we set up, whether they were the way we were trained to develop the solution or just the legal part of it. And, it was just -- we just can't do it.

And, I said, well, let's just find somebody else to pay for it. And, we did that.

And, I had -- I still have attorneys that yell at me because I -- you can't do that, you have to charge the Veteran. Because, it actually says we are supposed to charge the Veteran for that?

And, of course, when Jake and I saw

it, I was just like, this is absolutely insane. I'm not going to ask somebody to pay for a 10 percent discount. I mean, it was just ridiculous.

So, when we had somebody from the private sector who said, yes, sure, we'll pay for that. Okay, let's do that.

And, the Secretary has those flexibilities that has that flexibility to accept in kind and in cash to do things for Veterans. There's a process for doing that, let's just do that.

So, I think we have more solutions than we give ourselves credit for for some of this that we get stuck on the science sometimes. And, I don't mean to offend anybody that does that.

I mean, but, we do, right? We get, you know, the paralysis by analysis kind of thing. It's, you know, funny consultant type thing. But we do that sometimes with solutions is we just don't want to sometimes get there.

We're -- I think what you guys are going to be promoting is let's just get there, let's just do it and we'll figure it out.

DR. JONAS: That's wonderful, thank you.

If we were to point in the direction of here's some outcomes that everybody wants, you know, something along lines going, could -- would that help the VA and sort of build a flexible system that could say, all right, let's innovate. We can look at all kinds of innovative programs that might get at those outcomes as long as you show you're getting those outcomes.

Is that something that the VA is --

MR. O'ROURKE: I would much rather go to The Hill to advocate for a million dollars to try something that we really think are going to work than hide hundreds of millions dollars under things that I didn't realize we wasted money on.

I'd rather be intentional with it

and just say, yes, I'm going to go spend this money on this. I don't know if I'm going to get the exact outcomes, but I think it's going to be good for Veterans. I don't know a politician that wouldn't buy into that.

It's good transparency and, frankly, it's a great argument. It's a whole lot more interesting to talk about than some of the other things we have to advocate for for money. It's much more fun than an IT project, I know that.

MR. ROSE: Sir, if I may, along with this cross item that had come up, if we can look at it like increasing what we have in our toolbox to help the Vets and in lieu of costs that we might have spent on something else, I don't know, if we could just give it a little bit broader range.

MR. O'ROURKE: Yes, when we figure that part out, as narrow as that is, then we have found the Holy Grail of arguments on that.

I think the metaphor on the toolbox,

though, what's interesting and what I found in the little bit of traveling around that I have is that our VA folks probably do that to spite us.

Because, if they see something that works, they're usually are going to do it. Now, that's the good part about some of the independence of the way we're structured and also there's some negatives to that as well.

So, I think if we focus on that as really the drive, the initiative for these things, there's putting more in, some of these we'll want to mandate, right, and that will kind of cross us into that, well, okay, if you're going to mandate it, you better pay for it kind of thing.

We have lots of unfunded mandates anyway. So, I don't really usually buy that as an argument.

It's going to be compliance and accountability for those things. We can find the money usually to do them. And, usually,

some of this stuff, I mean, yoga, I'm sorry, my wife does like a bar class. It's, you know, $10 a class. I mean, we're not talking about huge --

I mean, I'm -- well, I should back up. I mean, we're the federal government, we can find a way to make yoga really expensive, I'm sure. But --

(LAUGHTER)

MR. O'ROURKE: -- maybe we can, you know, just farm that out and let the private sector do the yoga stuff and we just encourage them, maybe give a little, you know, way to do that.

But, I remember when we had the first chiropractor at Wright-Patterson, it was hilarious just talking to him about how his whole thing was working.

Because he was the brand new thing at the time and, you know, you all are more familiar with the history of chiropracting than I am. But, it was just interesting to hear his

travails and just trying to say, hey, I really think this can help people and, you know, and just --

And, we was there for six months and they booted him out. I don't know what happened. I'm sure they brought him back at some point. This was a while back. But, it was interesting.

DR. BEEMAN: Just a comment, sir.

I mentioned this to Jake earlier and I hope it doesn't offend Dr. Jonas at all, but I think we might be on the same wavelength. And, I'm speaking as a person from a major research institution having done my Doctoral work at another one.

And so, and that is, is it possible that the skepticism that appropriately characterizes modern medical science has led to cynicism when it comes to complimentary medicine?

Because, modern medicine is reductive, modern science is reductive and,

really, what we're talking about is more holistic.

So, it's almost impossible to prove some of this stuff except anecdotally. And, I think that that's what you were saying, Dr. Jonas, is that, you know, we see stuff and it works.

You know, all you need to do is get on a horse and realize that the worst headache in the whole world is cured within about five minutes because you start riding and you become one with the animal.

I do that all the time, that's how I reduce my stress. But, I can't scientifically prove that other than I know that it happens.

So, I'm glad to hear that you're open to that because I think there's a lot of things that we can do that treat people as human beings.

And, this goes back to one anecdote I have to tell you. I went to see physiatrist and a neurosurgeon about my back pain, my lower

back pain. And, he said, you know what? You don't need surgery, you need yoga.

So, I went home, I told my wife. She said, I've been telling you. And, I did yoga for about a month, no back pain. I haven't had back pain in at least five years.

And so, no intervention, no real cost to the system, maybe a little personal cost.

So, I think there's a lot of opportunity, but we just have to really grab it and put it out there.

MR. O'ROURKE: You said something that struck me and it's just for conversation.

So, treating the whole person as a human being. When was the last time we did that in DoD? We tend to do the exact opposite. Right?

I mean, you're an instrument. So, it is really a huge culture change. And, for the person, right? I mean, they're used to that, that we all grew up in that kind of

culture.

And now, we're coming to the VA asking people, you know, treat me as a human being. There's a cultural part of that, the change over.

And, what you brought out, and I'll let you guys fight that one out, but the reductive or not. But, it really is that your willingness or your ability to say, oh okay, I'll try that.

Or, is that what you even really want? Or do you want somebody just to listen to you? I'm in pain both physically, maybe mentally. I'm frustrated with life.

One of the things I have struggled with here, and especially -- and it kind of goes back to the story about the older Veterans, everybody has, and maybe this is just a person that already has this sort of mental image when they hear about a Veteran suicide. And, I guarantee it's not an 86-year-old person unless you're familiar with the statistics.

Usually, you think, oh, it's some, you know, I watched a movie and it's some kid that got back from Iraq and just can't deal with life, comes back and kills himself. That's the --

You know, or we've put him on meds and that's the kind of thing.

I've thought about this and, okay, somebody serves four years, six years, they get out, they go on with life.

They hit 42 and life kind of crashed in. They go through a mid-life crisis, whatever else, financial difficulties, whatever and then they consider suicide.

Completely decoupled from their service. I mean, this has nothing to do with -- I say that, maybe it's over simplification, but I mean, there's been enough time that's passed between their, you know, maybe they reflect back on that, but it wasn't enough trauma during that period that they were having those issues right after.

But, there's still one thing about them that makes them unique, at least from our perspective, they're still a Veteran. So, do I care about that person that has -- that Veteran who's mental health issues are not related to necessarily something I can pull a string on back to their service?

But, they're still a Veteran, they're still suffering. Do they come to us for -- do they come to us? Do they go to somebody else? Do we not have an equity in that person at that point?

You know, that part of it kind of plays into that, you know, somebody offers you -- it's not surgery, it's not drugs, whatever. Hey, go do yoga, go ride a horse, do those things.

Maybe that's not what they want to hear right then. I want somebody to listen to me, I want somebody to help me, my life's falling apart.

How do we recognize those things?

Or are we just focused on, well, your back pain, okay, you can get surgery, you've got a bulging -- oh you can do this, here's your options and then that's -- we just walk away from that, we just focus on that.

Which leads to just like what you said, I mean, I made a decision to go do yoga then a month later, I don't have the pain. Whereas, you could have just -- I'm sure you could have gone to other doctors who would have said, sure, come on we'll do laser surgery, we'll do some kind of surgery, something to you.

So, it's that mental state on some of those scenarios that are interesting to think through because, I don't know where all these folks are coming from.

And, that maybe the bigger picture is really determining where they're coming from and getting them into the right kind of care that they may need, that kind of stuff.

I don't know if even we're, as an

organization, our science, we're flexible enough to do that.

Those are some of the things I would love to start having a better understanding on or maybe I'm just, you know, don't read enough journals or something.

But, those are the kind of things that I hope we're smarter on through this process.

DR. JONAS: Sir, thank you for that answer. I'm totally on board with what you just said, I'd like to talk to you more about that.

MR. O'ROURKE: Good thing you're in the same room.

DR. JONAS: You know, I want to take a bit of an issue with something you just said about whole person care.

So, I practice in the DoD, I've seen folks working in the VA. They are taking care of whole people every single day. We are taking mind, body, spirit care every single

day. Okay?

But, we're doing it in a system that makes it really, really hard to do. And, that's the biggest -- that is the reason that the 50 percent of primary care folks, nurses, et cetera, are burning out. Okay?

We need to create it so it's easy to do. We need somehow an accountability ruler that says, as long as you hit these milestones in terms of quality, costs and outcomes, you can have the flexibility to do it through any path because we need multiple paths.

We need somehow to structure our system in a way that it brings in the evidence, but isn't tied to it as the only thing that's going to get paid for.

We need to somehow get an innovative model that allows for the whole person care to work better for what people are trying to do every single day, in my opinion.

So, can you bring an accountability ruler?

MR. O'ROURKE: Yes, I mean, I just ask why? I mean, why don't we have that system? If everybody's doing it, right, so here's the part that I just way over simplify, look at it, if that's the -- not if, but that's the case, why has there been no substantive reaction by the rest of the system?

The measurement system of that, you know, the payment system, what all those others are? Or, do we really just have two factions fighting against each other so would limit us in some places we don't actually do all that.

That's what I would lead to, typically an organization, right, if you're producing something a certain way, the rest of the organization eventually has to be forced into or is forced into some sort of alignment whether it's completely ineffective, whether it's whatever else, I mean, but you'll see something.

It's just you can't twist two gears two different ways and not sheer all the nubs

off and finally you just have two things spinning.

So, that's what I'm kind of wondering is, you know, what is those actions we can take as this leadership management, you know, our systems to align with that, if that's truly what we're doing, or is there not enough consistency there that we don't see the evidence coming out of that naturally. I mean, just overwhelmingly coming out and seeing it.

And, that's probably part of the struggles of all that anyway when you look at something that's hard to quantify, easy to qualify and so you just -- you're always warring between those two types of data.

I mean, I can tell you how I feel, I can't measure it for you. Right? I mean, well, one day I say it's my daughter suffers from migraines. Sometimes it's three times, sometimes it's seven. I'm always wondering, you're 16, is there something else going on? I mean, did you friend just call and piss you off

so now you're at a six? But, it's not really due to your pain?

I don't know those things so I just sort of usually step back and let it work and just be supportive and kind of try to create a cocoon around it.

I don't know if that's sort of the same reaction we're doing as an organization around some of the efforts. I don't know, I'll just -- things, put that in the list of things I don't know.

CHAIR LEINENKUGEL: Jamil?

DR. KHAN: So, first of all, personal thanks.

MR. O'ROURKE: It's good to see you again.

DR. KHAN: For getting those cards.

No, I have another request to you and this has to do specifically with the suicide prevention.

In the system, those that we have flagged that we know who are high risk, we

should be able to issue them a push card, the technology that exists today.

It can be procured from the same funding like you did for the cards.

(OFF MICROPHONE COMMENTS)

DR. KHAN: Yes, sir. Yes, sir.

Because, if Jamil has that, and let's say I'm one of those people who are ready to do it. There is a very much possibility that before I do it, I'll push it to say a last word to someone.

And, it should be answered not by a call center, it should be answered by a qualified technician who knows I'm ready to jump the San Francisco Bridge.

And, he says, Jamil, wait two more minutes. I mean, you're going to jump, and let's talk about it.

At present, evidence based has shown, not with this push card, but wherever there was an intervention, they had a high success rate.

So, my request to you is, get the push buttons out.

CHAIR LEINENKUGEL: Well, if anybody can get it done, it's going to be this guy right here.

MR. O'ROURKE: I mean, I've talked to the Amazon guys that have the -- we've been talking specifically in that context. But, the technology is there, the crisis line, you're right, it's a call center. And, we do track the number of interventions that they do and how many times we call out for register help, those kind of things.

My only -- and I agree in principle in all that. It's my concern, at least from this perspective, is having the capability and the resolution -- the capability to do the resolution on that to make sure that we don't get ourselves into where --

well, in an area we're already nationwide shortage and can I provide that capability with a reasonable belief that, you

know, within five seconds somebody's going to pick up the call, it's going to be that kind of interaction giving our number?

Or is there another way to find that solution that distributes that out to the providers that are out there that do those kind of services?

That's kind of the struggle with an organization this size and with a population this size, frankly.

DR. KHAN: Sir, you don't do that. The Jamil Khan, the Marine asked for this. He will, I'm sure, make this out.

MR. O'ROURKE: This is the forum. I mean, it's part of the recommendations. We can have those conversations. I know we've talked to Mr. Gates about other things.

DR. KHAN: So, the second thing I'm thinking of is the Choice Program. In the Choice Program, we started with regionally. The VA handled it itself.

Then, it became too big, so went out

and found a contractor that was Health Net.

MR. O'ROURKE: Two of the, but yes.

DR. KHAN: Yes, sir. The Health Net has done some good, but a lot of bad. The bad stuff gave the VA a bad name to all Veterans who otherwise were coming to the VA.

You know, once they get the bad name, unfortunately, it takes a long time to get a good name back.

But, recently, there are VA Medical Centers, I'm from Wisconsin, and medical center in Madison, they arrange my choice appointment with a provider and they paid directly to the provider. So, we have no issues.

I think it's coming from the ground. Marines like me asking you, don't bring me a third-party in there just let me take -- Veterans take care of Veterans.

MR. O'ROURKE: So, I mean, it's a broader issue. Yes, that's just a broad issue. I noted there's some things that make that much more complicated than it may seem.

And, success in one area, unfortunately, is not indicative of the whole system.

There's work to be done, there's balances to be made between that and where we're going to go. But, I would rather find the best solution in that case.

The one that you described for a couple of things, service good, cost very high. And, we would say we'll spend whatever we need to spend, but when it means not being able to do other services because we're going to pay that bill, I think we have to look for the best solution in those and make them work.

I mean, you're right. I mean, that's prefaced by that we -- I think we go back, we weren't doing that great before we had a choice. So, we had different places, individual places that did it a little better based on factors.

But, overall, we -- there was a reason why we went to the choice thing, there's

a reason why we went to third-parties. And then, there's a reason why we're coming back from that and there's reasons why we're going to go back to it, just doing it the right way, managing it the right way and the cost savings you can get from that don't outweigh any lack of service, but we need to be better competent on how we execute those kind of contracts.

Health Net will not be our contractor for very good reasons, although the DoD will be dealing with Health Net because that is now their new contractor, but I'll leave that to them. Maybe they can do a better job managing the contract than we did.

So, but that's noted, but I don't -- I think we'll just have to continue that conversation for a little while I think.

CHAIR LEINENKUGEL: You know, Mr. Secretary, it was nice, not only for you to be here, but we scheduled you for a half an hour and it's been an hour now.

MR. O'ROURKE: So, Meredith is

screaming at me right now?

CHAIR LEINENKUGEL: And, we could ask questions all day of you. And, we welcome you back at any time.

MR. O'ROURKE: Okay.

CHAIR LEINENKUGEL: And, whatever high profile role you're going to have in serving Veterans, but Peter, thanks for being a friend. Thanks for taking the time to come in front of the Commissioners of the COVER Commission. And, thanks for always being supportive of our requests and needs.

Thank you very much, sir.

(APPLAUSE)

(Whereupon, the above-entitled matter went off the record at 11:22 a.m. and resumed at 11:35 a.m.)

CHAIR LEINENKUGEL: I'm not going to apologize because it's always great to have an Acting Secretary or a VA leader in front of the Commission on the time.

DR. MURPHY: No apologies necessary.

I'm sure that that was more valuable to the Commission than --

CHAIR LEINENKUGEL: But, you were right in the heart of something that's very necessary and will be an outcome that we will be discussion and doing action on this afternoon as well.

So, by closure of the day 2 session, we will have at least key people in alignment as far as how we're going to go about and approach the work effort and then the type of support that we're going to request from you and your staff.

DR. MURPHY: Give me the opportunity to take a slight diversion. I just want to respond to something the Commissioners have said.

So, to give a low back pain example, and I and my trusty computer while everyone else was talking with the Acting Secretary, pulled up the low back pain guideline. And, I want to tell you what the recommendation is.

It is that they suggest the use of mindfulness-based stress reduction, clinician directed exercise, spinal manipulation and mobilization, acupuncture, pilates, yoga and tai chi for the treatment of chronic low back pain.

And, they had a specific key question about models and recommended a team approach including an interdisciplinary rehab team that included a holistic approach with biopsychosocial modeling.

So, you know, the guideline process, I think, works pretty well. Now, it's based on what the literature has published. And, some of the important work at places like NICoE may not have gotten into the literature yet.

But, where there's literature, I think, you know, VA has tried to pull in a lot of the things that this Commission is interested in.

And, that's, you know, one of the pain related guidelines and I think they did a

nice job.

DR. MAGUEN: If I can just add to that, I think one of the things you're highlighting is let's not replicate what's already been done. And, I think that that's a really key point.

I think that if we think about it that way, you bring to the table, look, I don't need to duplicate this work because we have good evidence here that this was done rigorously. Let's not, you know, waste time and duplicate work.

So, I think that that's, from my perspective, really important.

DR. JONAS: So, let's start with that recommendation around pain because we don't want to forget about pain. Right? It's a key issue around opioids, but not necessarily request that you replicate it. But, let's make sure we don't lose it.

DR. MURPHY: So, after we, you know, really nail down the scope, we're going to

start with what we had. And, once we nail down the scope, the next big piece is determining what your priority key questions are.

Because, they really begin to drive the search criteria and the systematic review.

So, remember that we said that we would start with PTSD, major depressive disorder, opioid use disorder, alcohol use disorder and suicide prevention. Five mental health conditions.

And, each of them needs three key questions. So, for adults with PTSD, are complimentary and integrative health treatments effective as monotherapy for improving mental health outcomes?

Meaning, no other therapy, only the complimentary and integrative health.

I think we're unlikely to find a lot of studies like that. But, if it works against placebo, then we've got a great recommendation based on the strength of the evidence.

The other two questions that I'd

like to propose to you is, for PTSD, are complimentary and integrative health treatments effective as adjunctive therapy?

And, we have to look separately at pharmacotherapy and at psychotherapy and psychosocial intervention.

So, those are the three questions and we would do the same thing for major depressive disorder, opioid use disorder, alcohol use disorder and suicide prevention.

So, that's a proposal. Let's go look at then what you do next in fleshing out some of these issues.

So, based on the key questions, we developed statements about the PICO(TS). We defined the population of interest, the intervention, what we're going to compare it to, the outcomes and, if relevant, the timing of the studies and the settings of the studies.

So, here is an example of a PICO(TS) table, population intervention. comparator, outcome, timing, setting that fills in all of

that stuff.

So, the population of interest, as we said, was adults 18 years or older with a PTSD diagnosis.

We've got the list from the legislation which we can potentially add to based on your input as the interventions and the -- since this is the monotherapy question, it's compared against either wait list or placebo.

The outcomes are the outcomes that the PTSD Work Group for the guideline determined were their outcomes of interest.

And, we'll look at at least a 60-day follow up to see whether the outcome -- the improved outcomes persist and we'll look at overall primary care, specialty care and mental health clinic care.

So, that's sort of the way we would fill that in.

We can go on, that's just a reminder of our population. Here are the interventions.

So, for monotherapy, we've got a list of interventions.

And then, for an adjunct therapy, you're going to look as your primary intervention at pharmacotherapy plus that list above and then psychotherapy plus that list.

And, what we did in the pharmacotherapy and the psychotherapy was we pulled out the evidence based-treatments from the guidelines.

So, we have the treatments that were determined to be effective in each of those guidelines.

When we look at the comparators, they're going to be slightly different, depending on whether we're looking at it adjunctive or at monotherapy.

So, for -- as we said, for the monotherapy question, if it's a primary therapy, wait list of placebo, for the comparisons and adjunct, you're going to look at pharmacotherapy alone or psychotherapy

alone.

And, here are some of the outcomes that have been determined by a panel of experts to be the important outcomes for each of the conditions that we're tasked by you to study.

So, rather than give you a headache looking at this incredible detail, what I would ask is that you, as a Commission, think about whether you want to set up subcommittees to oversee the evidence-based review and some of the other tasks that you want to carry out and we can work specifically to make sure that the PICO(TS) statements are exactly what you want to drive your literature review.

And, with that, I'd like to stop and open to questions. I know that I went through that really quickly, but we'll come back and talk about it later.

And then, I'd like to move to this survey if we could.

So, Mr. Chairman, are there question?

CHAIR LEINENKUGEL: Please go back to your PICO(TS) slide, if you would, that initial slide.

And, you did condense about eight slides into ten minutes. These are things that I think all of us as Commissioners want. I personally as the Chairman and I know that the Co-Chair would want to see, you know, this in a format.

So, again, once MAX is up, it'd be a great MAX entry point for us. But, we need this today because we are going to start to do the segmentation work led by myself and Tom as far as subgrouping, call it subcommittees, but how we're going to work.

And then, you know, is this the right model? Well, you've got it set up so I would imagine and assume that it should be.

It doesn't necessarily mean we have to stick rigidly to it. But, at least use it as a guideline while we do the subgrouping of our work.

DR. MURPHY: Sorry, we have actually developed the PICO(TS) statements and the tables for each of the conditions and each of the three key questions. So, we can give you that blown out document to give you all of the detail.

But, for brevity of presentation, we didn't put all of those into the slides.

CHAIR LEINENKUGEL: You did it the right way, Fran.

I'm just saying, though, as backup --

DR. MURPHY: Yes.

CHAIR LEINENKUGEL: -- give us the rest of the backup --

DR. MURPHY: Absolutely.

CHAIR LEINENKUGEL: -- with the detail behind it and then we can work off of that from the subgroup or subcommittee basis.

And, I think it'll give us a real good start in getting into the meat and the layering of what the Commissioners need to come

up with the solution basis and recommendations at the conclusion of the Commission.

But, at the same time, I look at these as working documents going forward. This is where the Commissioners will talk, whether it be telephonically or within subgroups first, which I highly recommend to get clarity.

And, also, I would say get consensus if possible from the subcommittees before bringing the work forward to the Committee.

So, I know I'm getting ahead of myself, but this is a, I think, a real good template for us to take a hard look at and it's something that is already there from the evidence-based work that you've done, Fran.

Everybody else agree to that?

(NO AUDIBLE RESPONSE)

CHAIR LEINENKUGEL: So, I think -- yes, go ahead, Wayne.

DR. JONAS: Just ask a couple particular questions, it seemed to be, and I guess if we have a subcommittee, then we can

talk about them.

But, I wouldn't -- you did put comparator which is wait list and placebo. I wouldn't exclude those that are comparators to others.

There are some studies in which the comparator is another treatment. It's not a wait list or a placebo, it's an actually active treatment and you're trying to do comparators.

So, I'd make sure we include those.

CHAIR LEINENKUGEL: I see that, yes, because I think I agree with you on that.

DR. JONAS: Well, so, there are some of these -- some of -- there are studies where some of these complimentary approaches have been directly compared to another treatment. Okay? Not a wait list or a placebo, but another active treatment like psychotherapy or some other treatment.

So, I just want to make sure those are included in the study, but it wasn't as an out on there. I assume you would.

DR. MURPHY: We can make those changes.

DR. JONAS: The 60 days, why 60 days? I mean, a lot drugs for depression are measured at 30 days. I know that FDA doesn't like that and a lot of people don't like it because people take them for longer.

But, that's the usual standard, or at least for depression drugs. So, why 60 days?

DR. MURPHY: I'd like to see some persistence of the effect. You also, especially for some of these conditions, like to give enough time, for instance, in the major depressive disorder, pharmacotherapy comparison takes a number of weeks for the drugs to become active.

DR. JONAS: Yes.

DR. MURPHY: But, again, we can --

DR. JONAS: I would encourage us to do that.

DR. MURPHY: -- open for discussion.

DR. JONAS: Okay.

DR. MAGUEN: That was something that stood out to me, too. I think that one of the challenges of the work that we're all about to do together, too, is that a lot of these studies probably, like, for example, evidence based treatment for PTSD is 12 weeks.

So, I would just suggest maybe looking to, if there's a pre and post, maybe we can think about time line a little together because I think it's a complex question.

I agree with you, what you're saying, we want long enough so that there's an exposure and a pre/post. But, the exact time line, I think, we might rule out studies that we want to look at that have a shorter time line.

DR. MURPHY: I think as long as you say at least X, we can always look at a year follow-up. But, you want to set some minimum time.

So, if the study is done a week

after and you know that your pharmacotherapy is not going to be active at that time, then it may not be a good study. It will be a very low quality study.

So, you're really looking at ways to define your inclusion criteria and your exclusion criteria.

But, again, we can work on that together.

DR. MAGUEN: Yes, I totally agree with that. I think we might, again, when we're thinking about that, just in thinking about some of the nuance, we might want to be more lenient when we look at just studies that have -- are looking at, you know, a CIH as primary versus CIH as secondary because there -- we might want to get sort of our hands around more studies in that number one category.

So, thank you.

DR. BEEMAN: Just an observation. We're calling it monotherapy and I think it's instructive. In reality, complimentary and

integrated medicine goes with something else. Right?

Complimentary means it compliments something. Integrated means that it integrates with something.

So, it may be instructive that in a -- that one of these complimentary therapies actually works on its own, then it might not be called complimentary anymore. Right?

It would be just non-pharmacologically based therapy or something.

DR. MURPHY: I --

DR. BEEMAN: I don't know, I'm just trying to get my head around it because I'm guessing, at the end of the day, this is going to be an easier sell for the VA if we say, these are approved complimentary therapies. They are in no way supposed to, you know, yes, replace, thank you, I'm to think of a more difficult word, but it's replace traditional therapies, you know.

But, maybe it's that this

complimentary therapy can help us mitigate the amount of pharmacology that we're using and all. Does that make sense?

DR. MURPHY: Yes, I'm with you. So, the reason I thought the three questions were important is that if you only at adjunct, we may get criticized by some of the advocates for transcranial magnetic stimulation and HBOT.

So, I think structuring it so that you look at it as -- and, remember, the recommendation from the PTSD guideline that was an example, was, you know, those treatments were not -- had insufficient evidence as a primary therapy. That was their term for monotherapy.

DR. JONAS: I think that's right.

I'd like to just have a language issue that I think what you described like around the pain assessment, that was very helpful, okay, in terms of framing this.

So, something similar to that would be good. That's evidence, that's what I call

evidence informed approach as opposed to what we heard earlier which is the evidence based definition, so evidence informed. Okay?

And so, because they have said, even -- we heard in the evidence based that there's insufficient evidence, that's their language, boom, end of story. Okay?

But, the recommendations for pain were we recommend you consider these into the guidelines. So, that's a little bit different, that's evidence informed practice. And, that may not go in your review process, but it should go in the contextualization that the Commission puts into this.

But, something that may affect your workload here is that it would be great to know the context around this, especially around pain. What are the current effects sizes for established, proven therapies for PTSD, depression, et cetera, the drugs, the psychotherapy?

What kind of effect size and

evidence levels do previous reviews, not yours, say you get in that? So that we at least have the context in which we're looking at these other therapies.

DR. MURPHY: So, full disclosure, I was the physician facilitator for the guidelines that we're talking about. So, I sat through the entire process, you know, worked -- Erica's one of my clients. Dr. Rodgers and Paula was the Chair of the PTSD Committee.

They went through, in detail, and they used the same process for both the low back pain guideline and the PTSD guideline.

The criteria for grading the recommendations is exactly the same. And so, the difference is based on the quality of the evidence, not on the process.

CHAIR LEINENKUGEL: Thank you, Fran. That's stage one of two stages that you have to present today. So, if you don't mind, could you move on to the recommended approaches and considerations to satisfy the patient centered

survey COVER requirement number one?

DR. MURPHY: So, while --

CHAIR LEINENKUGEL: Or duty to, I'm sorry.

DR. MURPHY: While we're waiting for the slides to come up, I'm going to take a similar approach. I'm going to truncate this discussion, but ask you for your advice and decision on the key issue, which is what options should we look at and how the survey should be carried out?

So, if we could go to the first slide?

Let me first show you what the legislation says about the need to conduct a patient centered survey, and that is their term, patient survey within each VISN.

Now, you saw the map of the 18 VISNs that exist across the country. So, we need to collect information from each of those areas.

And, we need to collect very specific information about the experience of

Veterans with the Department of Veterans' Affairs when seeking assistance for mental health issues.

So, what is the experience of Veterans?

Some of that, we can get from doing data analysis. But, VA does a Veteran satisfaction survey that's called the SHEP. And, that is done so that you can get information about patients who have received mental health care in each VISN.

And, in some cases, if we collected the information over a long enough period of time, we may even be able to say something about the experience of Veterans and their satisfaction with that care at a medical center level or a health care system level.

So, that's one option.

The other thing is, we heard yesterday that the National Academy of Medicine did look at experience of Veterans with -- who screened positive for mental health conditions

and they looked at both mental health, VA mental health users and for the second question, they also looked at the experience of OIF/OEF Veterans who had not used VA mental health care.

So, that helps us, and their focus groups and qualitative site visit information helps us with those, too, potentially.

There are also -- we're also asked to look at the preference of Veterans regarding available mental health treatments. And, that's a little bit more difficult.

What do Veterans believe is -- are most effective for them?

As well as, what do Veterans feel with respect to complimentary and integrative health therapies?

We've looked for existing surveys to help us answer those two questions. And, have not really found adequate data sources at this point.

We believe that the prevalence

question about what medication is prescribed to Veterans in mental health is a question that is best answered by querying the pharmacy benefits management database and looking at the clinical data warehouse so we can, with the help of the Office of Mental Health and Suicide Prevention, get access to that data and do that analysis for you.

I don't think that that's a survey question, but I'd be happy to discuss that.

The other issue is the outreach efforts of the Secretary. Again, if I were designing a study, I would want to collect that information from the VA.

We might ask in a survey whether any of the Veterans who are responding have participated in an outreach effort.

But, I think we can get a good sense of what VA does to outreach to Veterans with mental health issues including things like attending the transition assistance program, discharge briefings, going to stand downs,

participating in the PDHA and PDHRA activities as people fill out screeners and get, you know, as they redeploy from a combat theater.

So, there are a number of things that we know that VA is doing. And, we collect the information about what the outreach efforts consist of.

Now, let me go on to the next slide.

So, we really have three options, at a minimum. We can utilize exclusively existing qualitative and quantitative data sources to satisfy one or more of the Commission requirements.

But, as I've told you, there will be gaps if we do that.

We can design and conduct a patient centered web based survey to gather that information.

Or, we can use a combination of both, you know, using the existing data sources where they are available and then designing a survey to fill the gaps that are not covered by

the other information that we have.

We've talked a little bit about the Paperwork Reduction Act. It is a law, VA must comply. And, if we choose anything other than option one, which is using the existing data sources, we invoke this Act.

So, let me say a little bit about that very quickly.

The Paperwork Reduction Act triggers -- is triggered when VA wants to conduct any information collection from ten or more members of the public. The Veterans are the public, they're not government employees.

So, when you want to obtain that information, either by asking identical questions or identical reporting, record keeping and, if you want to write a report on it, a publication, it triggers this Act, ten or more, total for your entire activity.

Now, that process, after you've developed your survey instrument, you submit it to the Office of Management and Budget and they

go through a complex approval process, often coming back and asking a lot of questions and asking you to change some parts of your questionnaire.

And that can take six months to a year. So, it really impacts the time line for the Commission.

The good news is, that there is an expedited review process. We will have to work with OMB to see if they will let us use that.

If that's true, we could get approval, once we have a questionnaire to put before them, we could get concurrence from them within 60 days potentially.

Now, I don't think we can say that there will be public harm if they -- we go through the normal clearance process or this is an unanticipated event. But, maybe criteria number three is.

Because we will not meet the statutory deadline if we have to do this. So, I'm going to leave that up to all of you.

But, I think we -- what we need to determine together is, which of these options you want to invoke.

So, here's some potential challenges. There are information gaps and so, if you decide to use only existing data sources, you will not get experience of Veterans who use non-Department facilities and providers. And, we won't get a good information about the preferences of or experience of Veterans with complimentary and integrated health treatments.

If you pursue a new survey, then we've got to deal with the expedited review process or the routine review process.

So, the next step is to understand the existing data sources, evaluate what gaps there are, and I've given you my opinion about what the biggest ones are and then, choose an approach to meeting the requirements.

And, I'd like to stop there and answer any questions.

If you look at some of the appendix slides, we go through, in detail, each of the charges and tell you where we have found information. And so, that's there for us to look at in more detail at a later time, but I don't want to hold up your lunch going through that detail.

CHAIR LEINENKUGEL: Go ahead, Jack.

MR. ROSE: Mr. Chairman, just a question on option one. What kind of reliability are we going to get from that option and what percentage of the Veterans will be touched?

DR. MURPHY: So, each of the data sources is different. We heard from the National Academy of Medicine that they started with a population of almost 9,000 Veterans across the country covering every VISN. But, it's only OIF/OEF/OND.

Now, they did say in their report that there were some Veterans who were from earlier eras that got included in their site